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ABSTRACT

Of a group of 67 low-income first-time fathers-to-be, half were randomly assigned during the second trimester of pregnancy to participate in an intervention program designed to acquaint them with information, insights, and clinically appropriate techniques of responsive care for infants. Fathers were videotaped in feeding interactions with infants at hospital discharge and at 1 month of age. During two 1.5 hour training sessions, the Information and Insights about Infants (III) program attempted to sensitize fathers to fetal and early infants' characteristics and behaviors; the need for early and responsive attunement to infant state and signals of distress; and ways to modulate distress. Soothing techniques were modeled with a doll. Intrauterine bonding was encouraged through specific skin contact with the pregnant partner. Difficulties in recruitment were caused by fathers' lack of commitment to partner or infant, suspicion of a project about babies, drug and alcohol abuse, illiteracy, or personality problems. At maternity clinics, pregnant women were enlisted to encourage their partners to participate. Transportation to the clinic and oral presentation of questions helped ensure father participation. Early identification of fathers, skill and persistence of the intervenor, and continuity of caring were identified as prognosticators of success in reaching fathers-to-be. (RH)

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# Clinical Issues in Reaching Low-Income Fathers with a Program of "Information and Insights about Infants" (III)

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Running Head: CLINICAL ISSUES IN REACHING LOW-INCOME FATHERS



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Abstract

Of a group of 67 low-income first-time fathers-to-be, half were randomly assigned during the second trimester of pregnancy to participate in an intervention program designed to acquaint fathers with information, insights, and clinically appropriate techniques in responsive care for infants. Fathers were videotaped in feeding interactions with the infant at hospital discharge and at one month of age. During two 1 1/2 hour training sessions, the III (Insights and Information about Infants) program attempted to sensitize fathers to fetal and early infant characteristics, behaviors, and the need for early and responsive attunement to infant state, signals of distress and ways to modulate distress. Soothing techniques were modeled with a doll. Intrauterine bonding was encouraged through specific skin contact with the pregnant partner. Difficulties in recruitment were caused by lack of commitment of father to partner or infant, by suspicion of a project about babies, father drug and alcohol abuse, illiteracy, and personality problems. At maternity clinics, pregnant women were enlisted to encourage their partners to participate. Transportation to the clinic and oral presentation of questions helped ensure father participation Early identification of fathers, skill and persistence of the intervenor, and continuity of caring are identified as prognosticators of success in reaching fathers-to-be.

Clinical Issues in Reaching Low-income fathers with a Prenatal Program of "Information and Insights about Infants" (III).

Interest in the role of fathers with infants has grown sharply over the past two decades. (Honig, 1980; Lamb, 1977; Leonard, 1976; Parke, 1979; Pederson & Robson, 1969). Research on low-income fathers' feelings about their newborns prenatally and on their knowledge about infants is very scarce (Kliman & Vukelich, 1985). Our research project, from which clinical observations will be presented here, involved ascertaining fathers' perceptions of their infants prior to birth and after birth. Half of the fathers in this project were randomly selected into a prenatal program called "Information and Insights about Infants" (III). The III program, offered to low-income, first time fathers in a hospital setting, was a prenatal support program that included modeling opportunities as well as information about development and optimal interactions with infants in an effort to enhance paternal attitudes, knowledge, perceptions, and postnatal patterns of interaction. The program was conceived to test the hypothesis that, prior to birth, an intensive, albeit brief, intervention experience can enhance the sensitivities, knowledge, and abilities of fathers postnatally.

Subjects

During the early weeks of the second trimester of their pregnancy, women were enlisted to recruit their partners, who were low-income, first-time fathers. Seven recruiters were

trained to approach pregnant women in two publicly supported maternity clinics, one for low-risk and one serving high-risk clients. High-risk status of expectant women was indexed by one or more of the following conditions: hypertension, renal disease, Rh sensitization, history of two consecutive spontaneous abortions, incompetent cervix, documented active perinatal infections such as herpes, and uterine problems.

Nurses and social workers were most helpful in identifying pregnant women clients of the clinics who met two or more of the following low socioeconomic status (SES) criteria for inclusion in the project:

receives Medicaid

receives food stamps

receives public assistance

receives WIC

lives in subsidized housing

The 67 fathers recruited into the project ranged in age from 19 to 35 years. They did not need to be married to be included in the sample. The father who consented, agreed, 1) to participate in prenatal/postnatal assessments, 2) to accept random assignment either to the III intervention program or to the control group. After enrollment the fathers were then visited at home.

Research Design

The research design involved six subgroups of fathers. Within the respective high risk and low risk clinics, fathers were randomly assigned to one of the following groups:

High risk pregnancy, pretest and posttests, trained with III program (N=11)

High risk pregnancy, pretest and posttests, untrained with III program (N=11)

Low risk pregnancy, pretest and posttests, trained with III program (N=11)

Low risk pregnancy, pretest and posttests, untrained (N=11)

Low risk pregnancy, posttests only, trained with III program (N=12)

Low risk pregnancy, posttests only, untrained (N=11)

A Solomon-Postman 4-group design (Campbell & Stanley, 1966) was thus created for the low risk pregnancy fathers. During the two years of recruitment, few fathers were available in the high risk groups, and this precluded the addition of posttest only high risk groups.

Prenatal assessments were individually administered to each father by A. Pfannenstiel, research investigator, who also carried out the interventions and postnatal assessments. As a gift for participation in the project, fathers were given either a toy, an article of clothing, a book appropriate for babies, or a videotape of their interactions with their infants.

Training

Fathers who participated in the III training groups did so primarily in small groups of two or three fathers. Upon occasion, if some fathers did not show up for group sessions, the III training became a tutorial session for the father present, and sessions with the other fathers were rescheduled as tutorials also. All training took place at the pregnancy clinic, often during the time when the pregnant partner came for her scheduled prenatal checkup. Thus, the chance for a father to be present and to participate in the procedures was maximized because of the pregnant partner's appointment at that time.

Fathers experienced two 1 1/2 hour intensive training sessions. They each received an easy-to-read booklet illustrating infant development. Sessions included detailed information about the behavioral capacities of the neonate and of infants during the first year of life. The behaviors and functional capabilities of the unborn fetus were also described and attempts were actively made to induce intrauterine bonding of father to unborn baby. This bonding has proven successful in prenatal childbirth classes for pregnant women and the procedure has contributed to parental ability to mourn appropriately when an infant has subsequently died in childbirth (Olkin, 1986).

During the training sessions, timetables for infant development were reviewed. Discussions were held about ways in which fathers could elicit interactive behaviors and skills of a baby and ways in which he could tune into infant state, in order

to maximize infant comfort and receptivity for interaction. Responsiveness to infant cues and attentiveness to the timing of interactions to enhance responsiveness were emphasized through modeling with a life size doll. Fathers-to-be were encouraged to model with the doll. They were shown how to feed a baby a bottle, how to burp an infant, how to maintain an en face position, and how to adjust in holding a baby so that paternal postural adjustments reflect sensitivity to the changing needs of the infant. The importance of vocalizing, warm voice tones, responsive cooing turns, smiles and focused attentiveness to infant cues was stressed (Honig, 1985). Massage, skin stroking, and cuddling were demonstrated and fathers modeled appropriate tactual, holding, and feeding interactions with the doll.

During training, infant organizational processes were specified, so that fathers-to-be became aware of infant startle patterns, attempts of infants to self-comfort with hand-to-mouth patterns, the competence of infants in orientation to voice and in focusing on father's eyes when he leaned close to baby.

A variety of consoling techniques with an infant were taught. That is, crying patterns, lability of state, and irritability of newborns were discussed and soothing techniques, such as patting, holding to shoulder, singing/crooning, and father rhythmic body rocking, were demonstrated. Brazelton Neonatal Behavioral Assessment Scale (BNBAS) (Brazelton, 1982) items were used in a sequence of consoling. First suggested is an approach to the crying infant just with your face close, so

that the baby has the opportunity to achieve homeostasis and equilibrium by herself or himself. Next talk to the baby, saying soothing affirmative admiring words, such as "Oh you beautiful baby, you can get yourself calmed, you can get to calm down." Next, put a hand on the baby's belly while talking. Then gently rock the baby with hand still on the belly. Finally, pick up the crying infant, hold baby close, cuddle, and rock baby back and forth rhythmically while soothing with a reassuring voice.

Assessments

Pretest measures were administered individually early in the second trimester of pregnancy. Posttest measures were administered on day of discharge from the hospital and approximately one month post infant discharge from the hospital.

Assessments included measures of self-perception of the fathering role (Cronenwett & Wilson, 1981), demographic details on current family status, on family of origin and parenting received by the father, father attitude toward pregnancy, and willingness to participate in infant care after birth. Dyadic adjustment with the pregnant partner was assessed (Spanier, 1976) as well as sources of support that the father perceived as important for himself prior to and after the baby's birth. Paternal knowledge of infant development (adapted from Epstein, 1979) was assessed in terms of month at which father believed that an infant acquired or first exhibited an ability. Fathers' posttest ratings of their perception of the infant were adapted from Broussard (1980). Videotaped interactions of fathers

feeding infants were additional posttest measures added to the battery of assessments repeated after the birth of the baby. Posttest-only groups, of course, were only assessed after the birth of the infant.

Videotaped Interactions

Two videotapes of father feeding the newborn (either water, if baby was breast fed, or formula if infant was bottle fed) were carried out in standardized situations of 6 minutes father/infant together and 4 minutes father/infant with mother present. The first videotape was done in the hospital on day of discharge and the second videotaping was done in the home one month post discharge from the hospital. The videotaped interactions were coded by coders trained to satisfactory reliability with each of the authors. The coders were blind to the status of the fathers or the purpose of the research. The AMIS scale (Price, 1983) was adapted for coding the father-infant interactions, and was re-baptized the AFIS scale.

Clinical Factors In Recruitment, Assessment and Program Delivery

For clinicians who wish to provide prenatal services to low SES men who will be fathers and who are partners of women in high or low risk pregnancies, the dimensions of the recruitment process and the delivery of program present many pitfalls. What are some of the important considerations that this project has revealed in planning such programs for fathers?

Amount of Intervention Acceptable to Fathers

First, the amount of intervention that is planned for must be programmed in light of the realistic ability of staff to attract fathers-to-be for more than a few prenatal visits. Our original intention was to have six small group sessions with the low SES fathers served. Initial explorations made clear that fathers would not be willing to participate in a lengthy process or in numerous sessions. Two sessions of 1 1/2 hours each seemed to be manageable for the fathers in the III program.

Length of Time and Number of Contacts for Recruitment

Another problem involved the number and length of contacts required to recruit each father into the program. The majority of cases recruited into the III program took from 3 to 20 contacts with a single family for the father to come to the point that he would sign a consent form indicating his willingness to participate in this project. Recruitment was done in the pregnancy clinic, where women come at different time intervals. In the high risk clinic, mothers-to-be may come weekly or even twice-weekly. It may be easier to recruit partners of pregnant women who use clinic services more frequently, but our current data do not suggest that there were any differences between fathers recruited from either type of clinic. Fathers, across pregnancy type, felt that the pregnancy per se was a critical factor. Fathers did not seem aware of the special nature of the high risk pregnancy clinic. It was just perceived as a maternity clinic.

When approached by a recruiter who explained the project to her, a mother would say typically "I will talk to him and see if he is interested." She would come back for a clinic checkup or a sonogram and report about her partner: "He is still thinking." Then, on yet another visit, she would say "He will come to the clinic with me to talk to you on my next visit." Often, he would not come. Then, the recruiter would say "Well, I'll see you next time. We would very much like to have baby's father participate in this project". Thus, staff who wish to serve low SES fathers may have to build in realistic amounts of time and effort spent in recruitment.

Fear of possible death of the infant sometimes led to reluctance and delay in joining the project. One mother had lost two babies as miscarriages. The mom was a very heavy smoker. Each time she and the father would agree to participate. Then, they would renege on their commitment, saying "We want to see if this one will live." Each time they came into the high risk clinic for a check-up, the parents would be approached and asked "Are you ready to join in yet?" The reply continued to be: "We want to wait another week." It took over a month of twice-weekly clinic visits and recruiter contacts before this dad would sign the consent form.

Focus of Recruitment

Although the clinics were excellent places to meet pregnant women whose partners would be eligible for the project, sometimes the father-to-be simply would not be willing to accompany his

partner to the maternity clinic. If the mother reported that the father had said "Yes" but would not come to the clinic, the recruiter went to the home to have the father fill out the Phase I forms for entry into the project. No family was considered part of the project until the consent forms were signed.

Transportation Problems

Most of the fathers in the project did not have a car, yet the research design called for those fathers in the experimental intervention groups to receive training in the clinic setting. When the father could not come to the clinic with his partner during the day, AP would go to the home, pick up the father and bring him to the clinic for the training session. Thus, programs serving low SES fathers may have to provide transportation not only for outreach efforts to the home but also for program components that require father participation in a particular setting to maintain uniform conditions for participants in the intervention program.

Father Commitment to Partner and to Pregnancy

One strong variable that influenced success in recruitment was the status of the father's commitment to the mother and unborn baby. Sometimes, if the father was continually seen during clinic visits over a two month period, he would work through the problems of not being that interested either in the pregnant partner or in the baby, and would then be willing to sign the consent form.

Some of the pregnant women knew that the father of the unborn baby was not really committed to them or to the baby. Such a mother saw the father's participation in the project as being a potential way to rescue herself and bind the father and "hook him" into this pregnancy that she so wanted him to be part of. In about six cases, the mother used our project as such a mechanism. These fathers were involved in a long drawn out recruitment situation. Ultimately, however, none of these six fathers came into the program, although with the mothers' positive urging, strong efforts were made to recruit them until the last trimester of pregnancy. Almost all project fathers were recruited in the second trimester of pregnancy, but for undecided couples, sometimes the clinical recruitment situation lasted into the early third trimester.

Timing of Recruitment

During the second trimester, the fetus is moving, the pregnancy is "real", and this is a time of felt need. Thus, recruitment into program may be optimal during this period. Some projects recruiting single teen-age mothers into program have found that the immediate neonatal period in the hospital is also a sensitive period that optimizes chances for recruitment into a parenting program (Badger, 1977).

If the project succeeds in recruiting fathers early enough, then sometimes family difficulties and disturbances can be helped through referral, counselling, and provision of outreach supports to family beyond the program period.

Case Illustration 1:

One man went to live with another lady just after the baby was born. He had, however, participated in the prenatal assessment phase. His scores indicated disturbances in self-control and counselling was arranged for this father. Later on, he went back to the mother of the baby and they lived together and had a second baby.

Case illustration 2:

Rona, a very young, very attractive sixteen year old, had moved from family to family. She had no rapport with her mother. She could not get along in school, and had little trust in any other human being. Rob got Rona pregnant. Rona seemed to develop some trust in and confided in her project recruiter. She wanted very much to have her boyfriend be part of the project. The couple had an extremely rocky relationship however. He threatened to leave Rona from one week to the next. Alternately he expressed closeness to her. Somehow she convinced him to come to the clinic during one appointment, and AP made it a point to be present with the recruiter that day and spent three hours with the father in conjunction with the social worker at the maternity clinic. Rob seemed then to be very interested in supporting Rona throughout this pregnancy. In flipping a coin as to whether he would be in the experimental or control group, he flipped heads, so that he was in the intervention program. This recruitment effort, although long and difficult, helped stabilize this couple. They then moved in together. And they stayed together

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after the birth of the baby.

Case Illustration 3:

Although some fathers were, of course, randomly assigned into the control group after the initial phase of assessment collection, it was still possible to obtain help for the family if needed. One father had to be reported to a psychiatrist a while after the baby was born. This father, although in the control group, would never have been referred for help if not in the project. He had both alcoholism and bulimia. He needed help to see how both his problems were associated and how he could not relate to nor take care of his own baby with his problems. He agreed to go the hospital for treatment.

Illiteracy of Fathers

Some of the fathers recruited into the project were illiterate. Whether or not a father knew how to read, every item was read aloud to every father for each assessment.

Influence of Male Peer Group on Recruitment Success

A strong bias in some male sub-cultural groups against learning about or participating in programs involving babies may interfere with enrollment of some fathers in program. In one case, the father and mother were married and she attended the low-risk maternity clinic. Both thought that the project was a good idea. The father signed the consent form and filled in all Phase 1 measures. However, the recruiter needed the father to finish one tiny portion of the initial forms when the couple came to their next clinic appointment. But the father had just gotten a job and had begun to talk to other males at the job. The other

fathers at work all told him that the idea of sessions to learn about babies was the most nonsensical thing that they had ever heard of, and they pressured him so much at his new job that the father decided to drop out of the program. He was to have been an experimental father in the III program, but he did not continue.

Locating Project Families After Initial Recruitment

Many of the families that were recruited moved many times, and locating the family was an extremely difficult process. One family was traced through a local parish church. They lived in a hovel, but the father was very appropriate with the baby. He had had appropriate parenting experiences in his own background. Finding the family in order to film the one month post-partum interaction of father and baby took strenuous effort. Yet this father finally married the mother. Then he moved to Florida, held and lost 9 jobs, and has now come back to the city. When 11 months old, the baby died from crib death. Both parents are now in counselling since the mother felt very guilty and distraught about the baby's death. Because of their participation in the project, both were able to be helped to receive counselling.

Drug Abuse and Program Participation

Some of the most difficult situations that arose in project recruitment were due to father's drug abuse.

Case illustration A:

Dave was on drugs and also was a "wino". He was somewhat younger (25 years) than his partner (36 years). She was very

anxious to have the father participate. He would have signed the consent form, but he could not read, and had difficulty understanding the forms read aloud to him. He was so removed from reality, that when the recruiter casually mentioned that there was an author named James, he said that he was James's son. After three separate sessions, Phase I forms were completed. The initial videotaping had to be done in the home rather than hospital. At home, father commented that he had to spank the baby (under one week old) because she kept him up most of the night. The father was encouraged to try to figure out what the baby was trying to tell him by her crying so that he could help comfort the baby. The father said that this "was a lot of bull shit". The father always seemed high on drugs and alcohol. He drank throughout the whole last part of the pretest. He did come in for the two training sessions (he was in the experimental group) but never seemed to connect with or to get any understanding from the training.

The social worker at the high risk clinic was alerted that this father needed psychiatric care. When she approached him, he retorted that he was the son of an author and did not need psychiatric care. Arriving at the home for the post-test sessions, the investigator found the father in bed. He kept repeating about the assessment, "It's bullshit, just bullshit. One-half of these questions belong to her anyway" (referring to the mother). He refused to fill out anything but perception of infant and knowledge of infant assessments. He agreed to the

filming, but seemed to resent the procedure. Still angry at the baby, he reported being very annoyed that his spanking did not stop her crying at night. During the training sessions, this father had refused to hold any doll as part of the modelling process. Even when AP had urged him, saying "Just imagine that the baby is crying, what are you going to try to do?", he had refused. This father only seemed to relax when on hard drugs or alcohol. Mother reported that he beats her. She became pregnant by him with a second baby.

Case Illustration B:

Rose is a Native American mother, in desperate need of someone to love her and care for her. She was recruited in the low risk clinic and was able to persuade her partner to consent to participation in the project. He was randomly assigned to the control group. During the hospital lying-in, despite the fact that Rose had had a Caesarian, the father was with his buddies drinking and "doing dope". He was to go to the hospital on her release date, but he never showed up. Therefore, AP had to go to the home to do the first filming. When AP arrived at the home, the father was there with a crowd of friends, drinking and using drugs. Then AP asked if his friends could leave so that she could videotape him with his infant. During the filming, the father interacted well with his newborn and seemed to love the baby, although he acted very unappreciative of Rose. After the first filming, the family moved twice. Thus, at one month, they could only be found by seeking information from the grandmother.

Each time that AP came to the home to do the one-month videotaping, they were not home, or Rose was at home and the father was out with his pals. This control family was recommended for counselling but they never would go. After a sixth try at going to the home to film (the couple had now moved 4 times) when AP arrived the father was not there as he had promised. After an hour he did show up and was quite loving toward the infant during the videotaping. Soon after, this couple decided to marry and they have since had another baby. But the father is in jail now for theft. This is his second jail sentence. The mother reports that he steals to sustain his drug habit. The daughter who participated in this project is now two years old and the mother reports that the toddler is "totally unmanageable" and needs psychiatric help.

Violence and Sexual Abuse Cases

Participants in a project to serve low SES families may have to deal with patterns of intergenerational abuse including spousal beating and sexual abuse. Although our project only continued through the one-month videotaping of the father and infant, outreach work may well need to continue for families where violence is intergenerational and severe. That such continued assistance can make a strong difference can be seen in the following case illustration:

The Smith family was in the experimental group. Mr. Smith fought physically with his partner and hit her a lot throughout her pregnancy. There was no electricity in the house; no

facilities worked in the winter. The father was continually supported by AP through home visitations long after his project participation ended. As a therapeutic measure, AP gave the father free tickets to a bowling alley. At times he reported that "I was gonna fight, but I went to the bowling alley instead of hitting her up". When the infant was six months old, the couple got into a terrible domestic fight and the court gave the baby to the mother. After three days, the mother realized that she could not take care of this baby and she took it to social services and told them that she thought it should be given to the father. Alliance ( a local agency that deals with abuse cases) and social services have helped him and he now has full custody of the child. However, Mr. Smith lives with a man who was severely abused sexually as a child. The continued contact of AP with this family has resulted in the housemate's participation in therapy, which AP insisted on, since this man is the chief babysitter for the toddler while the father is at work. The baby has been attending a formal infant mental health program and is achieving normal scores on the Bayley Infant Intelligence scale.

In another family participating in our project, the father admitted that he beat his pregnant girl friend. This father was chosen by chance for the experimental group, and his dyadic adjustment scores improved markedly after participation in the two training sessions so that he was able for a while to make his relationship with the baby's mother more positive.

## Conclusions

Reaching low-income fathers prior to the birth of their infants is a viable and positive way to enhance their ability to bond to the unborn infant, to learn about infant development, and to begin to think about the needs of a baby and understand how to meet infant needs responsively. Such a program can serve as the basis for prevention services, since alcohol, drug abuse, spousal beating, and other problems such as stealing to maintain a drug habit, can be referred for treatment. Without the III prenatal program, such help would not have been offered to our families. Some of the fathers in this project seemed to have a disturbed self-image. One tried to commit suicide; several are currently in prison.

Fathers and their pregnant partners in these low SES families need early caring in the prenatal period and also long time provision of helping services. Many have extremely deep relationship problems, a conflicted family life, and difficulties in understanding and meeting human needs, so that even a tiny infant can be severely spanked for "bothering" a father.

The "Information and Insights about Infants" project shows what some of the core ingredients are that are necessary for serving fathers in chaotic, indifferent, disturbed, or destructive family situations. Early recruitment, staff skill and perseverance, and continuity of care seem to be the strong ingredients necessary to help fathers learn more nurturing and insightful ways of coping with their intimate relationships with

infant and partner. Identification of needs during the prenatal period makes prevention programming possible, rather than the inevitably more costly (in money and human tragedy) remediation that later programs will entail.

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